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Frohlich, Katherine L.

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The creation of a smoking class How prevention efforts can deepen social inequalities in health

Katherine L. Frohlich

Kurzgefasst: Die Verminderung sozialer Ungleichheit gehört in vielen Ländern zu den Kernzielen der Politik. Einzelne Elemente der Gesundheitspolitik können aber Folgen haben, die diesem allgemeinen Ziel entgegenwirken. Das zeigt das Beispiel der Nichtraucherschutz-Politik. Das Rauchen wird sozial stigmatisiert, und den Rauchern, die in zunehmendem Maße aus den ärmeren Schichten kommen, wird abweichendes Sozialverhalten vorgeworfen. Dies führt zu einer Verschärfung gesellschaftlicher Trennungen, die eigentlich aufgehoben werden sollen.

Summary: In many countries the reduction of social inequalities in health is an important policy goal. Some population-based public health interventions, however, may have effects that in practice conflict with these objectives. Current anti-smoking policies, for instance, are framing smoking as a deviant, undesirable, and morally repugnant behaviour. The discourse embraced by tobacco control and public health may be contributing to the stigmatization of smokers, thus adding to the process of "lumpenization" of smoking – and ultimately the social exclusion of economically disadvantaged smokers.

The reduction of social inequalities in health has become a high priority for public health in many countries, most saliently in parts of Europe. This priority is based on empirical evidence that reductions in social inequalities in health are not just important for the health of the poorest members of society, but also for their long-term positive impact on overall population health. Ergo, the lower the levels of social inequalities in health, the better off every member of society will be. But how to achieve this goal has become a subject of controversy. Equally importantly, some longstanding public health interventions may have effects that in practice conflict with these objectives. This friction can be illustrated by the example of smoking prevention efforts.

The trademark of public health interventions over the past thirty years or so has been the population approach, an idea partly inspired by the writings of Sir Geoffrey Rose, a British physician and public health epidemiologist. While its predecessor, the "high-risk" approach, focused strictly on improvement in those at high risk for a certain health problem or behaviour, the population approach seeks to ameliorate the entire population's health status. This was the basis of Rose's utilitarian proposal; the greatest gain for a population's health is experienced when every member improves her status on the health determinant of concern.

Rose surmised that this effect comes about only through universal exposure to the intervention. It is in this way, he suggested, that public health can achieve maximum beneficial effects on health. Successful interventions of this kind have involved speed limit reductions on highways, compulsory wearing of seatbelts, legal restrictions on public smoking, universal vaccination, and the list goes on. As can be seen from the examples, population approaches generally involve mass environmental control methods that attempt to alter society's behavioural norms.

Recent debate, however, has suggested that public health interventions based on the population approach may well improve the average level of a population's health, but may do little for, or may even worsen, social inequalities in health. For example, over the last 10 years or so, policies focused on reducing smoking rates in the general population have been successful in bringing population smoking levels down but are believed to be aggravating the social distribution of smoking along socio-economic lines. Indeed growing empirical evidence shows that smoking prevalence and incidence is following an increasingly steep social class gradient: people of lower educational attainment, in working class occupations and lower income levels experience lower rates of decline in smoking than other social categories, thereby creating a certain "lumpenization" of smoking.

How has this paradoxical effect come about? I would argue that the unintended consequence of the population approach is due to two oversights. First, the population approach functions on the logic that exposure to its interventions reduces everyone's risk by the same amount regardless of whether the individual is at great or minimal risk of the health problem in question. In practice, however, this does not seem to be the outcome of such interventions. Indeed, not every member of society has access to the same level of resources and capabilities permitting for an equivalent reaction to these interventions.

For instance, most public health innovations are taken up first by those members of society who are the most privileged. This phenomenon is known as the “inverse care law”, in which those with the most resources at hand will be best equipped to adapt to new situations, and hence, will be the first to derive maximum benefits from population-approach interventions. Unfortunately, however, the more privileged members of society are not always followed by their more disadvantaged peers. Population approaches to smoking cessation and prevention seem to have fallen prey to this problem and have thus, so far, been unable to address differential abilities to respond to these interventions.

The second oversight lies in the role that the population approach discourse may itself be playing in aggravating social inequalities in smoking. This discourse, that is, the way in which smoking and smokers are framed, is a “formal” system of knowledge. The discourse both delimits and makes possible what can be said and done about smoking; it produces notions about smoking that are considered “truths”. These “truisms” may be abetting the deepening of social inequalities in smoking.

Some examples of the current discourse are two commonplace assertions with regard to smoking: (1) cigarette smoking is a choice and; (2) youth smoking is correlated with truancy, excessive intake of alcohol and other risk behaviours. Neither of these statements is, however, objectively true. First of all, smoking, like any other health-related practice, is only in part a question of choice. As Max Weber argues people’s choices are constrained by the material resources or normative rules of the community or status group they belong to. These resources and rules are all components of what Weber referred to as life chances, the structural part of lifestyle processes. For Weber one cannot speak of the social processes that link structural constraints and opportunities (life chances) on the one hand, and people’s re-active or pro-active behaviours (life conduct, or choices), on the other. Thus, to suggest that people choose to smoke, without taking into consideration the structural constraints and opportunities that may have led to this smoking, is nonsensical. Second, smoking in youth is not necessarily correlated with other “high-risk” health-related behaviours.

What is of particular concern with the current discourse on smoking is the somewhat new relationship between tobacco control and the production of social class. This relatively new turn of events is particularly remarkable given that tobacco smoking was neither always viewed to be bad for one’s health, nor socially stigmatised. Indeed, at the turn of the 20th century, smoking was deemed to be safe when done in moderation by men. Indeed, for the upper classes (those who were the majority smokers at the time), smoking was often used as a social lubricant, a way of meeting people and putting them at ease.

In 1964 when the US Surgeon General’s report was released, providing definitive evidence of an empirical link between cigarette smoking and lung cancer, tobacco consumption was ubiquitous. Back then, 50 percent of men and 35 percent of women were smoking in the United States. Since 1964, and as a result of the report, there has been a remarkable shift in both the demographics as well as in the perceptions of smokers and smoking. Because of the reliance of the population approach on changes in societal norms, the discourse of tobacco control seems to be increasingly supporting pre-existing power relations. So, for instance, as smoking rates declined in the 1980s and 1990s, and more importantly as the social class composition of smokers underwent this dramatic shift downward, population approach efforts began to embrace a strategy of de-normalisation to shift societal norms about smoking, and hence, to reduce smoking rates.

As a result, even well-meaning interventions began framing smokers and smoking as deviant, undesirable, and morally repugnant. Indeed, it has been noted that it was only when tobacco consumption became concentrated amongst those of low socio-economic status that non-smokers’ rights groups were able to mount a successful attack on tobacco. From now on, it became easier for them to stigmatize smoking as an undesirable behaviour.



[Foto: David Ausserhofer]

Katherine Frohlich is Associate Professor at the Université de Montréal. During the academic year 2009/2010 she was guest researcher with the WZB’s Research Group on Public Health. Among her areas of interest are social inequalities in health, health promotion, social epidemiology and neighbourhoods and health.
Katherine.frohlich@umontreal.ca

As such, there seems to be a direct relationship between the changing social composition of smokers (that is, the widening gaps along socio-economic lines), and the transformation of smoking into a deviant and marginalised health-related practice. The discourse embraced by tobacco control and public health may therefore, in an unintended way, not only be the result of these social inequalities in smoking, but it may be further contributing to the very problem that it seeks to remedy (that is, the "lumpenization" of smoking). Indeed, it is important that we ask whether tobacco control and population approach activities are intersecting with histories of class oppression and injustice with respect to smoking for now not only are the poor stigmatised for their lack of economic fairing, but they also considered morally inferior for engaging in "reproachable" behaviours that other social classes have discarded.

So what can public health do to avoid such mistakes? And how can we reduce the burden on less fortunate members of society who become labelled and blamed for their poor health and behaviours? I suggest that a key aspect to all public health interventions and research should include reflexivity with respect to the social (and historical/material) location of the researcher and tobacco control practitioner. Public health functions too frequently on the presumption that there is a "right" response to specific practice scenarios which the "expert" practitioner will accurately identify, intervene on, and resolve. I suggest that the reflexive process might begin by exploring the role that tobacco control plays in shaping power relations and thus, in structuring social inequalities in smoking. A continuing and increasing emphasis on interventions that specifically target the needs of more vulnerable populations, such as low socio-economic status smokers, may be warranted.

Returning to Rose, public health interventions should therefore focus on both reducing population level problems, and reducing social inequalities in health. A key aspect to any reflexive project, in this respect, would also most likely include active participation on the part of those being targeted for the intervention. It may become apparent with local participation, for instance, that rather than targeting smoking, efforts should be made to reduce unemployment, or improve local school quality in order to reduce smoking rates in low income neighbourhoods. With this shift in awareness the practices of tobacco control might be re-shaped to diminish the increasing inequalities and alienation that are becoming the reality for many lower socio-economic status smokers.

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